Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Benlysta Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Systemic Lupus Erythematosus
  ICD-10 Code:_____
- ☐ Lupus Nephritis ICD-10 Code:_____
- ☐ Other Diagnosis:_____
  ICD-10 Code:_____

ORDER FOR BENLYSTA (BELIMUMAB):

- ☐ **Initial Dose: 10mg/kg IV at 0, 14 days, 28 days, then every 28 days thereafter x1 year**
- ☐ **Maintenance Dose: 10mg/kg IV every 28 days x1 year**
- ☐ **Other Dosing:_____x 1 year**

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS Pre/Post Infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____Fax results to:_____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., hydroxychloroquine, immunosuppressants, corticosteroids)?
☐ Yes ☐ No If yes, which drug(s)? _____

☐ Does the patient have a history of a positive autoantibody test?
☐ Yes ☐ No If yes, which test(s)? _____

☐ SELENA-SLEDAI score: _____

☐ Indicate any symptoms the patient has:
- ☐ Malar rash
- ☐ Discoid rash
- ☐ Photosensitivity
- ☐ Oral ulcers
- ☐ Nonerosive arthritis
- ☐ Pleuritis/pericarditis
- ☐ Renal disorder
- ☐ Hematalogic disorder

☐ Include labs and/or test results to support diagnosis
- ☐ ANA, Anti-dsDNA, Anti-Ro/SSA
- ☐ Other medical necessity documentation to support therapy: _____

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